U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

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CASE NOS.: 2001-BLA-453
2001-BLA-454

In the Matter of

FERN M. SMITH, o/b/o and as
Survivor of HARRY W. SMITH,
Claimant

v.

FLORENCE MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Robert J. Bilonick, Esquire
For the Claimant

George H. Thompson, Esquire
For the Employer

BEFORE: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from claims for benefits filed by Harry W. Smith, a deceased coal miner, and Fern M. Smith, his surviving spouse, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.*

Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on August 8, 2001 in Pittsburgh, Pennsylvania. The parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open for the submission of additional evidence and post-hearing briefs.

Notwithstanding Claimant's objection thereto, as contained in Claimant's letter dated July 27, 2001, and at the formal hearing, I find that good cause was shown by Employer for the submission of Dr. Fino's report (EX 5) within the 20-day period prior to the hearing, based upon Employer's pre-hearing correspondence dated July 18, 2001 and July 23, 2001, and its argument at hearing. Furthermore, the post-hearing submissions of depositions by physicians on behalf of the respective

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. At the formal hearing held on August 8, 2001, the parties agreed to proceed with the hearing, while reserving the right to challenge the application of the new regulations if they felt prejudiced thereby (TR 16-17). On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit issued its decision in *National Mining Ass'n, et al v. Dep't of Labor*, _____F.3d_____(D.C. Cir. June 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. However, as stated in revised 20 C.F.R. §725.2, the provisions of §725.309 (*i.e.*, duplicate or additional claims) are not applicable to claims pending on January 19, 2001. Furthermore, the provisions of revised 20 C.F.R. §718.205(c)(5) regarding pneumoconiosis hastening the miner's death simply codifies existing case law. Accordingly, I find that under the particular facts herein, the Amendments do not affect the outcome of this claim.

parties have been expressly allowed.[2] Finally, I note that the record consists of the living miner's claim and the widow's claim. However, the Director's Exhibits regarding the widow's claim were inadvertently not admitted at the hearing. Accordingly, I have *sua sponte* admitted the Director's Exhibits related to the widow's claim pursuant to §725.421 and §725.456. Furthermore, in order to avoid confusion, the Director's Exhibits in the miner's case are referred herein as "MDX," while the Director's Exhibits in the widow's case are designated as "WDX."

In summary, the record consists of the hearing transcript, Miner's Claim-Director's Exhibits 1 through 49 (MDX 1-49), Widow's Claim-Director's Exhibits 1 through 25 (WDX 1-25), Administrative Law Judge Exhibit 1 (ALJX 1), Claimant's Exhibits 1 through 6 (CX 1-6), and Employer's Exhibits 1 through 7 (EX 1-7). In addition, the oral and written closing arguments of the respective parties have been considered.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

Miner's Claim:

On February 20, 1981 (MDX 45-1), April 6, 1987 (MDX 46-1), and January 25, 1995 (MDX 47-1), Harry W. Smith, a former coal miner, filed applications for black lung benefits under the Act. All of the foregoing claims were denied. The most recent denial was issued by Associate Chief Judge Thomas M. Burke in his Decision and Order-Denying Benefits dated December 2, 1997 (MDX 47-53). The miner did not appeal nor take any further action regarding the foregoing claims. Therefore, the 1981, 1987, and 1995 claims were finally denied and administratively closed (MDX 49).

On August 27, 1999, Mr. Smith filed the current miner's claim for benefits under the Act (MDX 1), which was initially denied by the District Director's office on February 23, 2000 (MDX 17). By letter dated March 1, 2000, Claimant's counsel filed a timely request for a formal hearing (MDX 18). Subsequently, the District Director issued a "Proposed Decision and Order Denying Request for Modification" dated July 12, 2000, in which he referred to the Claimant's modification request dated May 8, 2000 (MDX 35). However, in light of Claimant's timely request for a formal hearing dated March 1, 2000 (MDX 18), the modification request was unnecessary. Furthermore, Claimant's

[2] The deposition transcripts of Drs. Perper, Yerger, Naeye, and Oesterling have been marked and received in evidence as CX 5, CX 6, EX 6, and EX 7, respectively.

counsel filed a second timely request for a formal hearing on the miner's claim dated July 19, 2000 (MDX 36), in response to the District Director's Proposed Decision and Order (MDX 35).

Widow's Claim:

On February 21, 2000, Harry W. Smith died (WDX 5). On May 8, 2000, his surviving spouse, Fern M. Smith (hereinafter referred to as "Claimant" or "widow"), filed an application for survivor's benefits (WDX 1), which was denied by the District Director's office on July 12, 2000 (WDX 11) and December 15, 2000 (WDX 20), respectively. In correspondence dated July 14, 2000 (WDX 12) and December 19, 2000 (WDX 21), Claimant filed timely requests for a formal hearing.

As stated above, a formal hearing was held before the undersigned on August 8, 2001 and the record was held open for post-hearing submissions. Following the receipt of such submissions, the record was closed.

ISSUES

The primary contested issues in the miner's and widow's claim, respectively, are as follows:

Miner's Claim:

1. Whether the miner was totally disabled (by a respiratory or pulmonary impairment).[3]
2. Whether the miner's disability was due to pneumoconiosis.
2. Whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. §725.309.

Widow's Claim:

1. Whether the miner's death was due to pneumoconiosis.

(MDX 48; WDX 24; TR 27-28; Employer's Brief).

[3]As discussed herein, the analysis of the "total disability" issue has been somewhat subsumed under the "causation" issue. While it is clear that the miner was totally disabled from performing his last usual coal mine job or comparable work due to his multiple health problems, one of the remaining outstanding issues in the miner's case is whether he suffered a total respiratory or pulmonary disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

A. Coal Miner

The Employer conceded, and I find, that Mr. Smith engaged in coal mine employment for at least 38 years, as previously found by Judge Burke (TR 27; MDX 47-53, p. 2). Furthermore, any discrepancy between the "at least 38 years" of coal mine employment found and the 40 years alleged in the miner's application for benefits (MDX 1) is inconsequential for the purpose of rendering a decision herein.

B. Responsible Operator

The parties stipulated, and I find, that the Employer, Florence Mining Company, is the properly designated responsible coal mine operator in this case.

C. Dependents

The former miner, Harry W. Smith, had one dependent for purposes of possible augmentation of benefits under the Act; namely, his spouse, Fern M. Smith. However, the Claimant, Fern M. Smith, has no dependents (MDX 1; WDX 1; TR 28-29).

D. Personal and Employment Background and Other Lay Evidence

The former miner, Harry W. Smith, was born on November 13, 1919. He married Fern M. Smith on December 21, 1939. They remained married until his death on February 21, 2000 (MDX 1,9; WDX 1; TR 28-29).

Mr. Smith left the coal mines in 1980, when he suffered a broken neck in a mining accident, and subsequently retired (MDX 45-1, MDX 46-1, MDX 47-1, MDX 1; TR 30-31). All of Mr. Smith's coal mine employment was spent in the underground mines in dusty conditions (TR 29-30). His last usual coal mine job was as a shuttle car operator (MDX 3; TR 30). On the "Description of Coal Mine Work and Other Employment" form, signed by the miner on August 24, 1999, he stated that the job entailed the following physical activities: Sitting-8 hours off and on; Crawling-4 to 8 hours off and on; Lifting and Carrying-75 to 150 pounds, 18 to 35 times per day (MDX 3). The foregoing is roughly comparable to the exertional level described by the miner in his testimony before Judge Burke on Mach 14, 1997. At that time, the miner stated that, in addition to operating the shuttle car, he also had to drag the rock dust bags, the tires, and machine parts. The rock dust bags weighed 50 to 80 pounds; and, the machine parts were so heavy that two people had to handle them. Furthermore, the miner testified that he routinely lifted more than 100 pounds (MDX 47-47, pp. 13-14).

Although the miner's neck was described as broken, Claimant testified that the miner underwent an operation. The neck was fused and Mr. Smith was again able to walk (TR 38-39). Subsequently, the miner also underwent back surgery (TR 39).

Claimant testified that her husband began suffering from breathing difficulties many years before he stopped working, and that he was told by a physician to leave the mines in the 1960's (TR 31). In addition, the Claimant stated that the miner's breathing condition worsened over time (TR 32). She estimated that her husband began receiving treatment with inhalers approximately five years prior to his death (TR 32-33), and that he was put on oxygen "a good year" before he died (TR 32). Claimant stated, and the medical evidence establishes, that the miner had a long history of heart disease. Claimant acknowledged that her husband underwent several cardiac catheterizations; that he suffered at least two myocardial infarctions, most recently in November 1997, and that he had surgery for an aortic aneurism (TR 49). Claimant also noted that her husband broke his left wrist when he fell off a ladder in May 1999 (TR 50). She also testified that her husband was hospitalized in 1999 with "sudden death syndrome," and that "they brought him back to life." (TR 50).

Claimant's daughter-in-law, Carol Smith, also testified at the formal hearing. The hearing transcript is somewhat confusing because Carol Smith sometimes interjected statements during Claimant's testimony (TR 42, 51-53). However, she was sworn in and subject to cross-examination by Employer's counsel (TR 43, 54-58). Carol Smith contradicted the Claimant's testimony regarding the 1999 admission for "sudden death syndrome," and stated that the miner was admitted for breathing problems and heart pain; that he went into tachycardia the following day, and underwent a catheterization (TR 51, 54-55).

Notwithstanding this conflict, the lay testimony consistently indicates that the miner suffered from shortness of breath, as well as a significant history of heart disease. Furthermore, the miner suffered other significant health problems related to his neck and back. This is borne out by the medical evidence, the most recent lay testimony, and the miner's earlier testimony before Judge Burke on March 14, 1997 (MDX 47-47).

Claimant acknowledged that her husband used to smoke (TR 34), but flatly denied the two pack per day, 44 year smoking history reported by Dr. Pickerill (TR 47). Claimant's testimony regarding her husband's actual smoking history, however, is somewhat ambiguous and conflicting, as set forth in the following exchange:

Q. When did he start smoking?
A. In 1940.
Q. And can you advise the Judge, did he ever have occasion to quit or stop smoking?

A. Oh, yes. I mean, when he first started he bought a — one pack of cigarettes and it lasted a whole week. He only smoked three cigarettes a day. And, then, he quit in 1945 because we bought our house. We bought a house from the coal mining town, you know, we bought one of their houses. And, then, he quit smoking.
Q. What year was that, ma'am?
A. What's this?
Q. What year was that did you say that you bought the house?
A. 1945.
Q. And go on.
A. From the Pittsburgh Coal Company. And he quit smoking then and he, he helped my uncle and my parents. They all bought a house, too. And we built cellars under them. And so that took a couple of years until they built those. He never smoked then. And then he would buy a pack of cigarettes after he got that built and we put furnaces in and every now and then he'd buy a pack of cigarettes. But he wasn't that, you know, never smoked that much.
Q. So he started smoking, though, after that initial —
A. Yeah.
Q. --stopped in '45?
A. Yeah.
Q. And how long did he smoke up to? Did he continue to smoke up until death or did he quit again?
A. Well, he bought a pack of cigarettes, he smoked about a half-a-pack. And, then, he quit in 1982.
Q. Now, ma'am, you say he quit in '82. Did he ever smoke again after '82?
A. No.

(TR 35).

I note, however, that Judge Burke found that the miner "smoked approximately one pack of cigarettes per day for approximately forty-six years until 1984 when he stopped smoking." (MDX 47-53). The foregoing is far more consistent with the miner's own testimony at the hearing on March 14, 1997. The miner testified that he began smoking at age 17 or 19 (1936 or 1938); averaged one pack per day; and quit smoking in 1984 after bypass surgery (MDX 47-47, pp. 17-18, 25). Since I find the miner's testimony regarding his own smoking history most credible, I adopt and incorporate Judge Burke's finding regarding this matter.

Medical Evidence

The case file contains numerous chest x-ray interpretations, pulmonary function studies, arterial blood gas test results, and medical opinions. With the exception of the post-hearing submissions and

deposition testimony, the medical evidence is adequately summarized in Employer's Pre-Hearing Report (ALJX 1). Except as otherwise modified or superseded herein, the medical evidence as set forth in Employer's Pre-Hearing Report (ALJX 1), is incorporated by reference herein. This obviates the necessity for a complete repetition of such evidence. Moreover, the miner's current claim is a duplicate one involving limited issues, and the only contested issue in the widow's claim pertains to the death due to pneumoconiosis issue.

In summary, Judge Burke found the presence of simple pneumoconiosis, as stipulated by the Employer and that the disease arose out of the miner's 38 years of coal mine employment (MDX 47-53, p. 2). Furthermore, Judge Burke explicitly found that the miner failed to establish total disability on the basis of the pulmonary function studies and/or arterial blood gases (MDX 47-53, pp. 3-4). However, there was no specific finding as to whether total disability was established under (pre-amendment) §718.204(c)(3) or §718.204(c)(4); nor was there an overall total (respiratory) disability determination made. Instead, Judge Burke focused on the disability causation issue and determined that the miner had not established total disability due to pneumoconiosis (MDX 47-53). In so finding, Judge Burke discussed the then recent medical opinions of Drs. Hanzel, Gress, Pickerill, Malhotra, and Fino. On the one hand, Drs. Gress and Malhotra concluded that coal worker's pneumoconiosis played a substantial role in the miner's total disability. On the other hand, Drs. Hanzel, Pickerill, and Fino opined that coal worker's pneumoconiosis was not a substantial contributor to the miner's total disability. To the contrary, Dr. Hanzel suggested that the miner may be totally disabled by coronary artery disease, but that he did not suffer from a significant respiratory impairment. Dr. Pickerill found a mild respiratory impairment with no significant deterioration since 1980, primarily due to tobacco abuse with pneumoconiosis as only a minor contribution. He attributed the miner's total disability to coronary artery disease, a previous neck injury, and lumbar spinal stenosis. Finally, Dr. Fino opined that the miner suffered from a mild, non-disabling ventilatory impairment, which he attributed to Mr. Smith's long smoking history. Regardless of its etiology, Dr. Fino found the miner's dyspnea was not disabling. However, Dr. Fino found the miner totally disabled by coronary artery disease unrelated to coal mine dust inhalation. In conclusion, Judge Burke found that the opinions of Drs. Gress and Malhotra that pneumoconiosis played a substantial role in the miner's total disability were not supported by the objective medical evidence; and, that the opinions of Drs. Hanzel, Pickerill and Fino were better reasoned and more consistent with the objective evidence (MDX 47-53, pp. 7-8).

While I adopt and incorporate Judge Burke's analysis of the previously submitted evidence regarding the causation issue, I also find that as indicated in the Decision and Order - Denying Benefits dated December 2, 1997, the miner failed to establish a total (respiratory or pulmonary) disability, as defined in the Act and regulations. As outlined above, the previously submitted pulmonary function studies and arterial blood gases failed to establish total disability under §718.204(c)(1) or (2). Furthermore, despite the miner's long history of heart disease, the record before Judge Burke did not establish cor pulmonale with right sided congestive heart failure, as provided in §718.204(c)(3). Finally, as discussed above, the better reasoned medical opinion evidence indicated that the miner's

respiratory or pulmonary impairment was not totally disabling as required under §718.204(c)(4), but that the miner's total disability was due to medical conditions unrelated to coal mine dust inhalation.

Since the presence of pneumoconiosis has again been conceded by Employer, and there is no credible evidence that the miner suffered from complicated pneumoconiosis (ALJX 1), further analysis of the x-ray evidence is unnecessary. In view of the progressive nature of pneumoconiosis, the most relevant medical evidence in the miner's claim consists of the more recent, post-final denial (12/2/97) pulmonary function and arterial blood gas test results and medical opinion evidence. Furthermore, the most relevant medical evidence in the widow's claim includes the medical (pathology and non-pathology) opinion evidence which addresses the death due to pneumoconiosis issue.

A. Pulmonary Function Studies

None of the valid pulmonary function studies submitted before Judge Burke's Decision and Order-Denying Benefits were qualifying (*i.e.*, through the 7/17/96 study) (MDX 47-53, pp. 3-4; ALJX 1).

The more recent pulmonary function tests were performed on August 5, 1999 (MDX 12), September 30, 1999 (MDX 10), and December 2, 1999 (MDX 39), respectively. Based upon the miner's found height of approximately 63.5 inches, which represents a compromise between the listed heights, only the December 2, 1999 pulmonary studies (before and after bronchodilator) are qualifying. However, Dr. Michael Sherman determined that the spirometry was invalid upon review, while finding the lung volumes and diffusions were acceptable (MDX 39). Moreover, I find that the nonqualifying studies conducted on August 5, 1999 and September 30, 1999 were essentially contemporaneous with those administered on December 2, 1999. Therefore, taken as a whole, I find that total disability has not been established based on the preponderance of the recent pulmonary function study evidence.

B. Arterial Blood Gas Studies

None of the arterial blood gas studies which had been submitted before Judge Burke's Decision and Order-Denying Benefits were qualifying (*i.e.*, through the 4/18/96 study) (MDX 47-53, p. 4; ALJX 1).

The more recent arterial blood gas tests were administered on September 30, 1999 (MDX 10) and December 2, 1999 (MDX 39), respectively. The Employer's Pre-Hearing Report misstates the results obtained on September 30, 1999 and inaccurately lists it as a qualifying study (*See* ALJX 1; *Compare* MDX 10). The actual results obtained on the September 30, 1999 blood gas test were as follows: PCO2-39, PO2-75 (MDX 10). The foregoing results are clearly not qualifying. Moreover, the administering physician, Dr. Malhotra, interpreted the test as "normal"

(MDX 11, p. 3). Similar nonqualifying results were obtained on the December 2, 1999 blood gas tests conducted by Dr.

Pickerill (PCO2-34, PO2-79), who also interpreted the results as "normal" (MDX 39). In view of the foregoing, I find that the recent arterial blood gas study evidence clearly fails to establish total disability.

C. Medical Opinion Evidence

As outlined above, the better reasoned medical opinion evidence submitted before Judge Burke's Decision and Order-Denying Benefits (MDX 47-53; ALJX 1), failed to establish the presence of total (respiratory or pulmonary) disability. Furthermore, such evidence failed to establish that the miner's simple coal worker's pneumoconiosis substantially contributed to the miner's total disability.

As summarized in the Employer's Pre-Hearing Report (ALJX 1) and supplemented by post-hearing submissions, the record contains the miner's more recent (post-final denial) medical opinions of Drs. Schaaf (MDX 12), Malhotra (MDX 11), Pickerill (MDX 13; EX 1), Yerger (WDX 6; CX 4,6), Naeye (MDX 31/WDX 7; MDX 33/WDX 9; EX 6), Oesterling (MDX 44/WDX 23; EX 7), Perper (CX 2,5), and Fino (EX 5), as well as the miner's death certificate (MDX 29/WDX 5).

Dr. John T. Schaaf issued a report dated August 5, 1999, with a cover letter to Claimant's counsel on the same date. Dr. Schaaf reported the miner's subjective complaints and physical findings (MDX 12). Although he reported a fairly accurate coal mine employment history, Dr. Schaaf grossly understated the miner's cigarette smoking history as "essentially nil...quit smoking in 1945, smoked maybe a third-of-a-pack a day for five years." (MDX 12, p. 1). Following his review of some of the medical records, Dr. Schaaf described the miner's smoking history as "somewhere between 0 and 30-pack years" (MDX 12, p. 7). In summary, Dr. Schaaf cited positive x-ray findings of pneumoconiosis, pulmonary function studies showing mild obstructive airways disease, and the miner's history of coronary artery disease. In conclusion, Dr. Schaaf stated:

> IMPRESSION: 1) coal workers pneumoconiosis.
>
> This opinion is based on the presence of coalworkers pneumoconiosis seen on chest x-ray, a compatible history of coal mine employment, and a concurrence as are manifest in other x-ray reports.
>
> 2) SEVERE CORONARY ARTERY DISEASE STATUS POST CORONARY ARTERY BYPASS GRAFT SUR-

GERY, STATUS POST PACEMAKER
DEFIBRILLATOR IMPLANTATION.

> His disability dyspnea is due, in my opinion, to a combination of heart disease and lung disease. The nature of his lung disease is his pneumoconiosis. Based on his long-standing history of breathlessness and exercise intolerance and relatively more recent history of progressive cardiac dysfunction, I suspect that the relative contributions of heart and lung were approximately equal.

(MDX 12).

Dr. Vijay K. Malhotra, whose opinion had previously been found unpersuasive, conducted a more recent pulmonary evaluation of the miner in September 1999 (MDX 11). Dr. Malhotra set forth the miner's history, subjective complaints, and physical findings. Furthermore, Dr. Malhotra noted the results obtained on chest x-ray, pulmonary function study, and arterial blood gas. The chest x-ray was interpreted as positive for simple (1/1) pneumoconiosis. Dr. Malhotra found a moderate obstructive and mild restrictive defect on the pulmonary function study; however, the results were not qualifying. Moreover, the arterial blood gases were not only nonqualifying, but "normal." (MDX 11). On the Department of Labor form report, Dr. Malhotra listed the following cardiopulmonary diagnoses: "1. Pneumoconiosis. 2. S/P MI, ASHD, S/P CABG, S/P _____ Pacemaker." The miner's pneumoconiosis was attributed to coal dust exposure, while the miner's cardiac-related diagnoses were associated with atherosclerosis. In response to further questioning regarding the severity of the miner's impairment resulting from the foregoing conditions, Dr. Malhotra noted: "Total Disability." However, he failed to provide a rationale for his opinion. Furthermore, he failed to specify the extent to which each of the diagnoses contributed to the miner's disability. Instead, Dr. Malhotra simply noted: "100%" (MDX 11).

Dr. Robert G. Pickerill, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, whose opinion had previously been found persuasive, conducted a more recent pulmonary evaluation of the miner in December 1999 (MDX 13; EX 1). Dr. Pickerill had previously examined the miner in 1996 and 1998 for his occupational lung disease claim, and also evaluated him for a pulmonary consultation at the request of his family physician, Dr. Stotler (MDX 13; EX 1; TR 41). Dr. Pickerill set forth the miner's background and occupational history. He noted that the miner only admitted to smoking 1/2 to 3/4 pack of cigarettes per day for 5 years ending in 1945. Furthermore, Dr. Pickerill outlined the miner's symptoms, medications, past medical history, family history, findings on physical examination, pulmonary function tests, arterial blood gases, electrocardiogram, and chest x-rays. Moreover, Dr. Pickerill reviewed the available medical records. In summary, Dr. Pickerill diagnosed the following conditions: simple coal worker's pneumoconiosis (Category I); mild to moderate COPD; coronary artery disease; mild to moderate restrictive lung disease due to cardiac surgery and possible amiodarone pulmonary toxicity; chronic arterial hypertension; previous fracture of a cervical vertebrae in 1980; and, lumbar spinal stenosis. In conclusion, Dr. Pickerill stated Mr. Smith only had a mild functional respiratory impairment when he retired in 1980; his lung function remained fairly stable until 1996; the miner's lung function has decreased significantly since his last evaluation in April 18, 1996;

however, this is attributable to the miner's worsening cardiac problem, which is unrelated to pneumoconiosis or coal mine employment (MDX 13; EX 1).

The miner's death certificate, which was signed by Dr. Vijay K. Malhotra, states that Mr. Smith died on February 21, 2000, at age 80, of cerebrovascular accident due to heart failure and renal failure (WDX 5). Clamant's counsel stated in his closing argument that the death certificate was completed without the aid of the autopsy (TR 61) and that the autopsy was not completed until March 15, 2000 (TR 69). However, the death certificate states that the autopsy findings were available prior to completing the cause of death notation (WDX 5, Item 28b). This apparent discrepancy may be explained by the fact that the autopsy was performed on February 22, 2000 (*i.e.*, two days before Dr. Malhotra signed the death certificate); yet, the date of transcription of the autopsy protocol was not until March 15, 2000 (WDX 6). In any event, the death certificate is not conclusive. Furthermore, the absence of any reference to coal worker's pneumoconiosis therein does not, in and of itself, preclude a finding of eligibility. Finally, Dr. Yeager, one of the prosectors, testified that he had only provided the attending physician gross observations and provisional diagnoses at the time the death certificate was signed (CX 6, pp. 37-39; *See also*, CX 6, Deposition Exhibit A).

The autopsy protocol was co-signed by Dr. Lakshmy Parameswaran, Resident in Pathology, and John Yerger, Associate in Pathology (WDX 6). The autopsy was performed on February 22, 2000 and was restricted to the heart and lungs. The autopsy protocol sets forth a gross description and microscopic description, as well as the following final anatomic diagnoses:

> Severe Occlusive Calcific Atherosclerotic Coronary Artery Disease with Occluded Bypass Graft
>
> Old Myocardial Infarction with Fibrosis and Repaired Ventricular Aneurysm
>
> Biventricular Hypertrophy
>
> Pericardial Adhesions
>
> Micronodular Coal Workers' Pneumoconiosis with Focal Emphysema
>
> Pleural Adhesions

(WDX 6).

In addition, the autopsy protocol included the following clinical summary:

> This 80-year-old, white male with a history of repaired ventricular aneurysm, cardiac bypass grafts, congestive heart failure and chronic renal failure was admitted to Conemaugh Memorial Medical Center with complaints of shortness of breath on 2/20/00. His condition deteriorated and he was pronounced dead on 2/21/00 at 2135 hours.

(WDX 6).

Finally, the autopsy protocol included the following clinicopathological summary:

> This 80-year-old white male died naturally of multi-organ failure. Severe coronary artery disease with occluded bypass graft and coal workers' pneumoconiosis are contributing factors.

(WDX 6).

Dr. Yerger, who is Board-certified in Anatomic and Clinical Pathology (CX 1), also issued a somewhat cursory supplemental report, dated June 29, 2001 (CX 4). Dr. Yerger stated that he had "re-reviewed" the autopsy protocol, microscopic slides, and autopsy findings, as well as other listed medical data (CX 4). The report included only two paragraphs of text, and more than two pages listing the medical data. In summary, Dr. Yerger stated:

> In my opinion, Mr. Harry Smith was afflicted with coal workers' pneumoconiosis at the time of his death. Mr. Smith had micronodular coal workers' pneumoconiosis with silicotic features and associated centrilobular emphysema. In my opinion, the coal workers' pneumoconiosis with centrilobular scar-type emphysema was of sufficient severity to have been a substantial contributing factor in his death. The emphysema, through hypoxemia, aggravated the underlying severe arteriosclerotic cardiovascular disease leading to his death.

(CX 4).

Dr. Yerger also testified at deposition on November 14, 2001 (CX 6). While acknowledging the seriousness of the miner's cardiac disease, Dr. Yerger reiterated that the miner's coal mine dust exposure was a substantially contributing cause of the miner's death (CX 6).

Dr. Richard L. Naeye, who is Board-certified in Anatomic and Clinical Pathology (EX 6, p. 4), issued an initial report dated June 14, 2000 (MDX 31/WDX 7). Dr. Naeye noted the miner's history of cardiac disease and renal failure, as well as the miner's terminal hospital admission with complaints of dyspnea. He also described the gross and microscopic findings on autopsy. In conclusion, Dr. Naeye stated:

> INTERPRETATIONS: A mild, to moderately severe simple coal worker's pneumoconiosis (CWP) is present. It is comprised with a moderate number of anthracotic macules and micronodules. Those with cores comprised of irregular layers of hylanized collagen have a silicotic origin. The death certificate lists cardiac and renal failure as the causes of death. The postmortem findings and other information available support this conclusion. Did the CWP that is present cause disability or hasten the miner's death? Based on the limited information available to me the tentative answer is no. This answer is based on the fact that the centrilobular emphysema is mild to moderately severe in the tissues available for microscopic review. Even with the severe focal emphysema that is present around anthrasilicotic macules and micronodules overall the visible emphysema is too mild to have caused significant impairments in lung function. This conclusion could change if additional medical evidence emerges that this man experience years of severe, chronic bronchitis or clinically significant airway obstruction prior to death. To be convincing this latter evidence would have to include the results of pulmonary function studies and arterial blood analyses. All of these latter data would be needed because no bronchi were included in the tissues removed for microscopic examination. When present, chronic bronchitis is easily identified by the microscopic examination of bronchi.

(MDX 31/WDX 7).

In a supplemental report, dated June 26, 2000 (MDX 33/WDX 9), Dr. Naeye reported a fairly accurately coal mine employment history of "at least 30 years" ending in 1980, when he retired due to a neck injury. Dr. Naeye also reported a relatively accurate smoking history of one pack per day for 45 years, but noted that the miner quit in 1990, not 1984. Dr. Naeye also referred to additional clinical information which had become available, including multiple chest x-rays, medical records of various physicians, and the results of various pulmonary function studies and arterial blood gases. In pertinent part, Dr. Naeye noted that the pulmonary function studies were "normal in 1996," but "revealed subnormal FEV1 and FVC values" in September 1999. Furthermore, the arterial blood gas studies in 1995 and 1999 consistently yielded "normal" pO2 values. In view of the foregoing, Dr. Naeye opined that the etiology of the miner's dyspnea was cardiac, not pulmonary. In conclusion, Dr. Naeye stated:

> INTERPRETATIONS: This man had normal results of pulmonary function studies and arterial blood gas analysis 16 years after he had quit mining coal. Simple CWP does not advance after a miner retires from the industry unless rather severe silicosis is present or complicated CWP appears (Citations to medical literature omitted). Neither of these last two developments took place in Harry Smith. He developed respiratory problems the last 3 years of his life because of progressive cardiac dysfunction with resulting heart failure. There is no basis for postulating that his simple CWP caused impairments in lung function, contributed to any pulmonary insufficiency or caused any disability. The dyspnea on exertion of his last 3 years of life was the consequence of his

> progressive cardiac failure. In summary this man's CWP was always too mild to have caused any disability or to have hastened his death.

(MDX 33/WDX 9).

Dr. Naeye also testified at deposition on July 13, 2001 (EX 6). While acknowledging that he had been handicapped by the limited clinical records provided (EX 6, p. 11), Dr. Naeye reiterated that based upon the available information, and the relatively sudden change in the miner's condition, the miner's coal mine dust exposure did not cause or contribute in any way to Mr. Smith's death or lifetime disability (EX 6, p.45).

Dr. Everett F. Oesterling, Jr., who is Board-certified in Anatomical Pathology, Clinical Pathology, and Nuclear Medicine, issued a report dated December 19, 2000 in which he analyzed the histological slides while utilizing photomicrophages and also referred to the miner's extensive records (MDX 44/WDX 23). Dr. Oesterling discussed the autopsy slides and reported that "there was a mild micronodular coalworkers' pneumoconiosis present." However, Dr. Oesterling also stated, in pertinent part, that "this degree of disease appears insufficient to have altered pulmonary function, thus it would not have produced lifetime disability nor would it have hastened or contributed to this gentleman's death." Furthermore, Dr. Oesterling cited the autopsy findings of the miner's heart disease, in particular, an "intrapulmonary hemorrhage that has resulted from marked passive congestion due to a failing left ventricle," as well as "hemosordin, a breakdown of hemoglobin that has been released by the rupture of the red blood cells...(which)...denotes the passive congestion and hemorrhage have been present for some duration." In addition, Dr. Oesterling cited other histologic findings which indicated that the miner's "heart was severely damaged by his arteriosclerosis." Moreover, Dr. Oesterling cited the medical records which showed the miner's long history of heart disease and treatment thereof with multiple surgical procedures throughout the period from 1994 to 1997. Finally, Dr. Oesterling cited histologic evidence of centrilobular emphysema, which he attributed to the miner's extensive smoking history, not mine dust exposure. In conclusion, Dr. Oesterling stated that the miner's "limited coalworkers' pneumoconiosis is insufficient to have in any way contributed to or hastened his death." (MDX 44/WDX 23).

At deposition on August 2, 2001 (EX 7), Dr. Oesterling reiterated the foregoing opinion. While acknowledging that the miner may have had a moderate obstructive and/or mild to moderate restrictive lung disease a year before his death, Dr. Oesterling reiterated that the foregoing conditions did not produce a clot in the graft vessel nor did it in any way produce the cardiac crisis which led to the miner's death (EX 7, pp. 158-159). In summary, Dr. Oesterling stated that the miner's centrilobular emphysema was not directly related to mine dust exposure, and that the miner's lung impairment due to coal worker's pneumoconiosis was not of sufficient magnitude. Therefore, he found that pneumoconiosis did not in any way hasten or contribute to the miner's death (EX 7, pp. 45-46).

Dr. Joshua A. Perper, a Forensic Pathologist and Medicolegal Consultant, issued a lengthy report dated May 10, 2001, in which he summarized various reported smoking and occupational histories, as well as the available medical evidence. Furthermore, Dr. Perper provided his own findings on microscopic examination of the autopsy tissue, and answered various "medicolegal questions." In addition, Dr. Perper included some citations to medical literature and attached appendices to his report, which showed that the notes of Dr. Stotler, the miner's treating physician, listed COPD and CWP, as well as other medical conditions, in 1994 (CX 2). In summary, Dr. Perper concluded:

> 1. Mr. Smith had evidence of significant coal workers' pneumoconiosis with silicotic features, and associated focal (scar) and severe centrilobular emphysema.
>
> 2. Mr. Smith, a coal miner with a long standing occupational exposure to coal mine dust as a miner, developed coal workers' pneumoconiosis as a result of long standing occupational exposure to coal mine dust.
>
> 3. Coal workers' pneumoconiosis with related centrilobular emphysema, was a substantial contributory cause of Mr. Smith's death, both directly and through hypoxemia, and through causing, precipitating or aggravating a fatal arrhythmia in a patient with severe arteriosclerotic heart disease.

(CX 2).

Dr. Perper reiterated the foregoing opinion in his deposition testimony on July 23, 2001 (CX 5, p. 49). However, Dr. Perper acknowledged that the mechanism of death is inconsistent with those stated on the death certificate, which not only did not mention coal worker's pneumoconiosis but also failed to mention chronic obstructive pulmonary disease. Finally, Dr. Perper cited the miner's treatment with oxygen supplementation during a hospitalization in January 2000 and at home, as the basis for his conclusion that the miner suffered from hypoxemia prior to death. Dr. Perper conceded, however, that to his knowledge no arterial blood gas tests were performed after December 2, 1999 (CX 5, pp. 108-111).

Dr. Gregory J. Fino, a B-reader and Board-certified pulmonolgist, had previously issued a reviewing report, dated May 7, 1997 (MDX 47-50), which was found persuasive (MDX 47-53). In a supplemental report dated July 19, 2001 (EX 5), Dr. Fino briefly summarized the autopsy protocol and the conclusions of various pathologists; namely, Drs. Naeye, Oesterling, and Perper. Based upon the foregoing, Dr. Fino opined that the miner's "death was not due to coal workers' pneumoconiosis. Instead, it was due to coronary artery disease." (EX 5).

Discussion and Applicable Law

As set forth above, the Employer has conceded, and I find, that Mr. Smith had simple pneumoconiosis during his lifetime. Furthermore, there is no credible evidence which rebuts the presumption that the disease arose from the miner's 38 years of coal mine employment. However, the foregoing findings were previously reached by Judge Burke in his Decision and Order Denying Benefits, dated December 2, 1997. Accordingly, those findings do not represent a material change in condition under §725.309.

As outlined above, the recent pulmonary function study evidence is mixed. However, the validity of the December 2, 1999 results is questionable. Moreover, other, virtually contemporaneous pulmonary function studies, dated August 5, 1999 and September 30, 1999, were not qualifying. Therefore, taken as a whole, total disability has not been established under pre-amendment §718.204(c)(1). *See also*, Revised 20 C.F.R. §718.204(b)(2)(i).

As stated above, the recent arterial blood gas study evidence is not qualifying. In fact, the most recent results were interpreted as "normal." Therefore, total disability has not been established under pre-amendment §718.204(c)(2). *See also*, Revised 20 C.F.R. §718.204(b)(2)(ii).

Notwithstanding the miner's long history of heart disease, there is no credible medical evidence that the miner suffered from cor pulmonale with right-sided congestive heart failure. Accordingly, the Claimant has not established total disability under pre-amendment §718.204(c)(3). *See also*, Revised 20 C.F.R. §718.204(b)(2)(iii).

Finally, I find that the Claimant has failed to establish the presence of total (respiratory or pulmonary) disability on the basis of the medical opinion evidence. Although Dr. Schaaf opined that the miner's "disability dyspnea" was due to a combination of heart and lung disease, he failed to specifically address the question of whether the miner could perform his last usual coal mine job or comparable work from a respiratory or pulmonary standpoint. Moreover, Dr. Schaaf grossly understated the miner's cigarette smoking history. Furthermore, the rationale for Dr. Schaaf's conclusion is not adequately explained, in light of Dr. Schaaf's finding of only "mild obstructive and some restrictive lung disease" on pulmonary function testing (MDX 12). Similarly, I accord little weight to Dr. Malhotra's disability finding. Dr. Malhotra failed to fully address the questions posed on the Department of Labor form report and/or to explain the medical rationale for his conclusions, particularly where, as here, the pulmonary function study results were nonqualifying and the arterial blood gas values were normal. Moreover, Dr. Malhotra also grossly understated the miner's smoking history as only one pack per day from 1940 to 1945 (MDX 11). Dr. Pickerill stated that the miner's lung function had decreased significantly since his last evaluation of the miner in April 1996. However, Dr. Pickerill did not specifically make a total (respiratory or pulmonary) disability finding. Moreover, as discussed above, Dr. Pickerill cited a questionable qualifying pulmonary function study. In contrast, the

arterial blood gases were normal. Furthermore, Dr. Pickerill expressly found that the decrease in lung function is

attributable to the miner's worsening cardiac problem (MDX 13; EX 1). In view of the foregoing, I find that the medical opinion evidence does not establish the presence of a totally disabling respiratory or pulmonary impairment under pre-amendment §718.204(c)(4), or by any other means. *See also*, Revised 20 C.F.R. §718.204(b)(2)(iv).

Assuming *arguendo* that the miner had established the presence of a total (respiratory or pulmonary) disability based upon the more recent medical evidence, this would not establish a material change in conditions under §725.309 because this element was not specifically found as the basis for the prior final denial (MDX 47-53). For the purpose of finding a material change in conditions, the miner would have to establish total disability due to pneumoconiosis. If this threshold issue were met, then I would have to make a *de novo* review of all of the evidence, old and new, to determine whether the miner was entitled to benefits. Furthermore, with respect to the widow's claim, I must consider all of the relevant evidence to determine whether the miner's death was due to pneumoconiosis as defined in the Act, regulations, and case law.

The Third Circuit has held that pneumoconiosis must be a "substantial contributor" to the miner's total disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3d Cir. 1989). Similarly, the provisions of revised §718.204(c)(1) state that "a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment" (*i.e.*, pneumoconiosis had a material adverse effect on the miner's respiratory or pulmonary condition; or, it materially worsened a totally disabling respiratory or pulmonary condition which was caused by a disease or exposure unrelated to coal mine employment). Furthermore, the cause or causes of the Claimant's total disability shall be established by means of a documented and reasoned physician's opinion. *See* Revised 20 C.F.R. §718.204(c)(2).

Since the Claimant has failed to establish the presence of a totally disabling respiratory or pulmonary impairment, he clearly cannot establish total disability due to pneumoconiosis under amended §718.204(c). Moreover, I find Dr. Pickerill's opinion regarding the etiology of the miner's functional impairment to be persuasive. In making this determination, I find Dr. Pickerill's opinion regarding the etiology issue most consistent with the miner's longstanding history of heart disease; the miner's less than disabling respiratory or pulmonary impairment condition many years after he left the coal mines; the reversibility shown on some pulmonary function studies; and, the normal recent arterial blood gases. Furthermore, Dr. Pickerill not only examined the miner twice in conjunction with the miner's black lung claim, but he also conducted a pulmonary evaluation of the miner at the request of the miner's family physician. Finally, as discussed below, I find his disability causation finding most consistent with the credible, medical opinion evidence regarding the death due to pneumoconiosis issue. Accordingly, the miner's current claim must be denied.

Death due to Pneumoconiosis

Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by §718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivors' claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at §718.304 is applicable.
>
> (4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.
>
> (5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. §718.205(c).

As outlined above, Dr. Malhotra did not mention pneumoconiosis nor any other respiratory or pulmonary condition on the miner's death certificate (WDX 5). Although Dr. Malhotra had examined the miner on at least two occasions, the death certificate, in and of itself, is not well reasoned. Furthermore, Dr. Malhotra apparently did not have access to the complete autopsy protocol when he issued the death certificate. Among the other physicians of record, Dr. Yerger and Dr. Parameswaran, who co-signed the autopsy protocol, first stated that coal workers' pneumoconiosis was among other "contributing factors" of the miner's death (WDX 6). Thereafter, Dr. Yerger specified that coal worker's pneumoconiosis was a "substantial contributing factor" in his death (CX 4, 6). Similarly, Dr. Perper opined coal workers' pneumoconiosis with related centrilobular emphysema, as well as hypoxemia, was a substantially contributing cause of the miner's death (CX 2, 5). On the other hand, Dr. Naeye opined that coal worker's pneumoconiosis did not cause or contribute to the miner's impairment or death (MDX 31/WDX 7; MDX 33/WDX 9; EX 6). Similarly, Dr. Oesterling opined that the miner's limited coal worker's pneumoconiosis was insufficient to have contributed to or

hastened his death. Dr. Fino's opinion also buttresses the conclusions of Drs. Naeye and Oesterling (EX 5).

Although Dr. Yerger, a prosector, is one of the physicians who found that pneumoconiosis was a substantial contributing factor in the miner's death, I find that the opinions of Drs. Oesterling and Naeye, as buttressed by Dr. Fino, are better reasoned and are entitled to greater weight than those of Drs. Yerger (and Parameswaran) and Perper. In making this determination, I find that the opinions of Drs. Oesterling, Naeye, and Fino are most consistent with the miner's extensive history of cardiac problems up to and including the time of his death and the miner's less than disabling respiratory or pulmonary impairment, as evidenced by the preponderance of the nonqualifying pulmonary function studies and the normal arterial blood gases only a few months prior to the miner's death. In view of the foregoing, I find that the Claimant has failed to establish death due to pneumoconiosis under Section 718.205(c) or by any other means.

Conclusion

Although the Claimant has established that the miner had simple pneumoconiosis arising from his 38+ years of coal mine employment, the evidence does not establish that he was totally disabled due to pneumoconiosis. Therefore, the Claimant has not established a material change in conditions under §725.309. Furthermore, the evidence does not establish that pneumoconiosis caused, substantially contributed to, or hastened the miner's death. Accordingly, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claims of Harry W. Smith (Deceased) and Fern M. Smith, his surviving spouse, for black lung benefits under the Act are hereby **DENIED**.

A

ROBERT J. LESNICK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.